Health Home Quality Improvement Workgroup - 5/25/2022

Participants

Pamela Lester IME	**Heidi Weaver IME**	LeAnn Moskowitz IME
Tami Lichtenberg IME	**David Klinkenborg AGP**	Sara Hackbart AGP
Tori Reicherts ITC	**Bill Ocker ITC**	**Flora Schmidt IBHA**
Susan Seehase IACP	**Kristi Oliver Children's Coalition**	Paula Motsinger IME
Stacy Nelson Waubonsie	**Amy May Waubonsie (Left at 9:30)**	**Geri Derner YSS**
Jen Cross Orchard Place (Left at 10:40)	**Kim Keleher Plains**	**Andrea Lietz Plains**
Melissa Ahrens CSA	**Christina Smith CSA**	**Faith Houseman Hillcrest**
Ashley Deason Tanager	**Stephanie Millard First Resources**	**Kristine Karminski Abbe**
Shawna Kalous Plains	**Rich Whitaker Vera French (Joined at 10:30)**	**Jamie Nowlin Vera French**
Crystal Hall Tanager (Joined at 9:30)	Brooke Johnson Abbe	Mike Hines Tanager
Karen Hyatt DHS	Ericka Carpenter Vera French	Kelsey Poulsen Tanager
Krystal Arleaux Orchard Place	**Kellee McCrory U of I**	

Notes

Last meeting Notes:

- No questions/concerns from group.

Reviewed topics discussed during last Meeting

- Discussed the 99490 and the informational codes in the Director's meeting. There was ambiguity on changing this. A survey will be sent out to all of the directors as a follow-up to the meeting.
- Discussed potential change to a high, medium, low tiering and either using all of the same tool to determine tier or a crosswalk to ensure all tools will get to the same result.
- No questions from the group.

Draft Workgroup Report:

- Kristine Karminski - on page 3 the group is recommending 2 bullet points. The first bullet is the same as in the SPA (Page 19) and the 2nd bullet is a condensed version. Just needing some clarification on what we are recommending.
    - Page 3 of IHH Workgroup Report:
        - *SPA Page 19, the group recommends making Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported to the State two bullets.*
            - *Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported by the State and Lead Entities.*
            - *Participate in ongoing process improvement on clinical indicators within the Health Home.*
    - Pam will review and provide some feedback.

Follow-up items (Slide 11)

- Nothing from the group to add from yesterday's discussion
- Pam - will be conducting a survey regarding 99490 and informational codes. Also ask about using all of the same tool to determine tier or a crosswalk to ensure all tools will get to the same result.
    - Results of the survey will be discussed with this group.

Member Qualifications: (Slides 12 & 14)

- Information from this slide is out of Federal guidance (slide 13)
    - Geri Derner – bullets [on slide 14] are an impairment with getting kids enrolled. We have lost several members for enrollment because we haven't got the documentation (haven't been able to get more than just a diagnosis). This is an extreme hardship.
    - Kristine Karminski - in the past, if someone had a diagnosis not on the list the IHH would document the functional impairment. This was a significant change to have a LMHP do this.
        - Pam - heard that this was a struggle and big change.
    - Pam - What do you think would be the best thing to propose for member qualifications?
        - Geri Derner - have a number of kids that have a qualifying diagnosis from a primary care provider but can't use what comes from the medical doctor.
        - Stacy Nelson - biggest barrier is the LMHP. When using the DLA 20, we are holding that assessment to a higher standard.
        - Andrea Lietz - agree with Geri. Make sense to use the functional impairment done by IHH to justify enrollment and accept diagnosis regardless of if it is a MHP or medical doctor
        - Christina Smith - was this change after the OIG audit? Concerned that was looking at early times of the IHH. Systems since then have been developed. Concern is we are putting strict things in place and swung too far.

- Geri Derner - agree with Christine. Dramatic response to an old audit [Audit period was before managed care] and doesn't recognize the changes in processes/procedures put in place that we didn't have before. Take a step back, trust the tools that we use to assert the questions and not rely on another entity to answer the questions
- Kristine Karminski - has impacted our relationships in the community. One provider charged us to send DocuSign documents. This is a burden. Challenges in getting patients in. Staffing challenges are affecting all.
- Christina Smith - This is also an issue/barrier for adults and transition youth as well as child IHH providers.
- Pam - we discussed using the DLA 20 for risk-based tiers before. Would you consider using it for functional impairment as well?
    - Kristine Karminski - need to explore this as well, there may be additional costs. Will the BA/BS level be able to complete it and be a function impairment without LMHP?
        - Andrea Lietz - we have Care Coordinators (CCs) (BA level) and therapists completing it as well as others like psych providers.
        - Kim Keleher - initial cost and fidelity cost associated with this
    - Dave Klinkenborg - there is concern too many member/families are not really connected to BA services in a substantial way. A benefit of the LMHP having to be part of the enrollment process that member have the basic building block. If we don't require this, how do we ensure members in other areas of the SPA are engaged with the LMHP?
        - Christina Smith - by making the LMPH the gateway, it prevents members from getting the basic services at first. Gentle hassling. Forcing kids to see a therapist may not work. The LMHP wants engagement, but some kids don't want to see a therapist.
        - Bill Ocker - would like to discuss this further. What options do we have outside of IHH? Both make great points. Value stream mapping for this would be beneficial. Want to know how to help and if there are things can be done before they become a part of the IHH.
        - Christina Smith - if they need to just get started, hate to see them not to be in an IHH because they don’t' want to see a therapist.

- Summary
- Pam - what we are hearing is requiring the LMHP provides burden and a bottleneck for getting services for members. In 2016 SPA there was a list of diagnoses, if member's diagnosis didn't fall under that list then a functional

impartment had to be done. Between the 2016 and the recent SPA, what can be done to better coordinate services for the member? You have expressed that the SPA overcorrected from OIG audit. What can be done to find the middle ground?
    - Kristine Karminski - some of the feedback was around can the person providing the diagnosis be broader than the LMHP? Can it include Primary Care? Can the functional impairment be completed by the IHH by the BA/BS level instead of the LMPH?
    - Melissa Ahrens - we should be able to use hospital psych documents.
    - Dave Klinkenborg - A BH enrollment should be a fast track to IHH enrollment
    - Bill Ocker- do we have anyone we can talk to at hospitals about this? Hearing hospitals wont' do this, do that.
        - Pam - when first came back to IHH program, Marissa and I presented to the IHA, asking for to collaborate with them, we were met with silence.
        - Kim Keleher- someone mentioned previously the LMHP are not doing initial assessments, so they don't really have the documentation and have to create it. It is easier when we have internal providers. With external providers it is a challenge to get documentation.
            - Geri Derner - have a few providers in town and they tell us they don't have an assessment. This requires members to be seen again so an assessment can be done. This increases Medicaid's costs.
- Pam - where do we go from here?
    - Bill Ocker - will talk to ITC leadership about hospitals not sharing information for care coordination.
    - Geri Derner- reduce the need to have a functional impairment for every member. Maybe if the member has a diagnosis of x, y, z (from a diagnosis list) for example a functional impairment is not needed. Only do the functional impairment for those who do not have a diagnosis on the list.
    - Dave Klinkenborg - there are some activities we can look at. Core issue is a therapist or hospital to cooperate. Bigger than IHH. CMHW slot releases, MCO can help "shake the tree" a bit in a collaborative way. If need an extra phone call to help/support the current issue, the MCOs can help. We can have some continued discussion regarding obtaining records from providers.
    - Kristine Karminski - anyway to simplify process. The MH system is taxed. Sometime one more piece of paper is the tipping point for the day. Staffing is an issue. We need to look at the whole system and remove barriers (what is essential and what can be more efficient).
        - Christine Smith - Agree with Kristine. I am all about removing barriers to getting people into the system that is already very taxed
    - Geri Derner - restore the list of auto-approved diagnoses so that we won't have to go through the extra steps. And give credit to new processes (CASH).

- Kristine Karminski - encourage us to look at current ICM CASH and non ICM documentation that would meet functional impairment rather than another document that is required.
    - Pam - Would the group like to review the documents and come back next meeting to discuss?
        - Yes, the group would like time to review
        - Reviewing the criteria for functional limitations and review documents
        - Pam to put in the Workgroup Report:
            - To restore the list of qualifying diagnoses
            - Broaden the definition for what provider type can provide the diagnosis
            - Allow the functional impairment tool to be completed by the IHH (group will review CASH and Non-ICM assessment)

Provider Qualifications: (Slides 15-17)

- Reviewing Rule for Nurse, what recommendations would you make for this role?
    - Kristine Karminski - reading the rules is still unclear. My takeaway is the LPN needs to take direction from an RN, but the LPN can do most of what the RN can do but most of the things that the LPN can't doesn't have to do with IHH. Not sure if my perspective is accurate?
        - Pam - LPN cannot do the first assessment. RN must sign off all of their documentation. LPN cannot give clinical recommendations.
            - Geri Derner - Some have nurses that don't want to be bogged down by the work that needs to be done. What we are asking our nurses to do is not really nursing.
                - Pam - What is the minimum requirement to be in the role (different from the HH service)?
                - Karen Hyatt - We currently reviewing the LPN Role.
                - Pam - what do you think about adding an LPN to support the work (would still need RN)? Do think this is a potential recommendation?
                    - Karen Hyatt - reasonable recommendation
                    - The group would like some time to think this through
- Reviewing Rule for Care Coordinator, what recommendations would you make for this role? (Include CMH/Habilitation Requirements) (slide 17)
    - Melissa Ahrens- exception for the CC that has another degree in another field and has experience.
        - Geri Derner- support appropriate experience in lieu of education. If there was a way to have xx of years of experience to supplement a degree, I would support that.
            - Others agree
        - Karen Hyatt - things we are hearing is that sometimes the Peer Supports are asked to do CC work. How is that happening?

- Pam - Peering and Family Peer support should not be competing tasks required by the CC. Need to flush this out with the HH Service discussion.
- Pam - if you hired someone with experience, how many years of experience would they need?
  - Kristine Karminski - maybe 3 years (based off of case management)
    - Group agrees

- Pam - ICM work will need to meet requirements for managing the services. Is there anything we need to enter in here to address that? So, do we address CMH/Hab requirements for the CC?
  - Kristine Karminski- example we hire someone that had a health-related degree but only 5 months experience. That person did non ICM work until they got the 1-year experience. So, if they have a health-related degree but only some experience can work with the non ICM population until they have enough experience to work with ICM population.
    - Kim Keleher - depends on the eligibility and criteria that makes someone ICM. Right now, the only criteria is if they are CMH and Hab rather than going by the functional assessment. Are we going to change that? Carving out different criteria for CC is different.
    - Pam - if we did low, med, high rather than the 4 levels what would that look like?
      - Rich Whitaker - agree, difference from ICM vs non ICM, that does change what you would expect from staffing. Changes the aspect of the assessment and gives more a stratification of your population. Needs into 3 different areas.
        - Pam - even if we change to low, med, high if you had a CMWH may score low.
        - Kim Keleher - for CMH/Hab would they still need to meet the qualifications to be the CC for that population?
          - Pam - yes, the CC would still need to meet the requirement for that rule.
          - Rich Whitaker- if a person is in a high category, the nurse may be more involved, if the person is in a low category, the nurse may be more in a consulting role.
          - Pam - can cover this during HH service discussion.
- Pam - need to parse out the ICM and non-ICM discussion. The focus is anyone that does not have Hab or CMH. How can we be flexible with the

SPA so they can do services for that population? Focus on those who do not. What can we be flexible with for the CC?
    - Kristine Karminski - expand to accept a CC with non-Health related degree but has experience to work with non ICM. This would allow for flexibility.
    - Kim Keleher- that would allow for greater flexibility in hiring.
    - Pam do you think there should be a note in the SPA - if it is a CMH/Hab member would call out still need specific experience with those?
        - Kim Keleher - yes, be clear as possible.
        - Kristine Karminski - yes, if leaving the tiers the same. If changing will need to update with whatever that path would be.
            - Group agrees
- Reviewing Rule for Peer Support and Family Peer Support Specialist, what recommendations would you make for this role? (I did ask DHS to weigh in on this) (slide 17)
    - Kellee McCrory -
        - FPSS Training - comprised of online and in-person training. The online portion is done first. Training prepares participants for certification through the Iowa Board of Certification. Have evidence-based training and role playing. Currently offer 3 trainings per year (8-12 people). These folks work all around the state.
        - PSS - these are folks that have lived experiences and are doing well in recovery. Most are working to get trained in the role they are in. Training 20 to 25 people, 5 times per year.
            - We are considering moving to 4-day training.
        - There is a Peer Advisory Board consisting of about 75% peers.
        - With testing, we expect a 70% or higher and is proctored
        - For both FPSS and PSS training both are rigorous, and evidence based.
        - For further questions on Peer Training, contact kellee-mccrory@uiowa.edu.
        - For more information on training: https://iowapeersupporttraining.org/
- Kristine Karminski - Peer Support role is for 19 and older, is there an option for teenage peer support (16-18 years old) to be in a Peer Support role?
    - Kellee McCrory - we do training at 18. Issue is if someone that young is ready to take that on. See the value of this. Hoping to include those aged out of foster care.
    - Christina Smith - can tell if they are ready or not. Haven't interviewed under 18 but would like to see if they were. Would be valuable. The biggest issue is that the kids in that space are working and going to school, finding time for training is difficult.
- Richard Whitaker - do you travel to other areas to train?

    - Kellee McCrory - Yes, we do training across the state. Has been a huge interest in this area. All trainers are peers (working as peers). We are working to build a deeper bench in the workforce.
    - Richard Whitaker - if the initial training could be less intense and have a booster training later in the year, that might be helpful. It could help us in our retention.
        - Kellee McCrory - we do additional training, CEUs, etc. Training is set up as a packaged deal. Want to be sure they are fully trained when working for you.
- Karen Hyatt will send information to Pam to add to SPA for the Peer and Family Peer Support Training Requirements.
- Health Homes can partner with Karen from DHS and Kellee U of I to improve training.

<u>Next Steps</u>:

- Follow up items from today:
    - Be ready to provide thoughts and feedback about adding an LPN (would still need an RN) to support the work at our next meeting.
    - Review current ICM CASH and non ICM documentation to see if it could meet functional impairment rather than having another document that is required. Be ready to provide your thoughts and feedback at our next meeting.

- Reviewing Health Home Services:
    - At our next meeting be ready to provide your thoughts and feedback on each section based on Federal guidance and the scope (State) of each role.
        - Each HHS has four sections
            - Definition
            - Health Information Technology
            - Benefit/Service can be provided by…
            - Description (Who can do what under this HHS)

- Pam will update the workbook based on feedback today.